EXHIBIT 11

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MATTHEW RAYMOND

DATE OF REPORT:	**July 23, 2021**
DATE OF EXAM:	**August 25, 2020**
DATE OF ACCIDENT:	**September 15, 2016**
DATE OF BIRTH:	**June 17, 1988**

Preliminary Information:

My curriculum vitae, which summarizes my qualifications, is attached as Exhibit A to this report. Over the past four years, I offered testimony in the following matters: Mary Arney through Diamond Medical (January 10, 2018 video deposition); Joyce Donovan through Legal Med (June 13, 2014 trial testimony); and Catherine Heary through Legal Med (November 21, 2014 trial testimony). I am compensated in this matter at a rate of $350 per hour and have to date received $2,000 for my preparation of the instant report.

Identifying Information:
Mr. Raymond is a 32-year-old male referred for evaluation of symptoms allegedly related to the accident of 9/14/2016. All historical information is based upon statements made to me by Mr. Raymond, unless otherwise indicated. Mr. Raymond's history and physical exam took approximately 70 minutes. Mr. Raymond's wife, Ms. Michelle Raymond, was present throughout the examination.

The exam was performed at the DeGraff Wellness Center during the COVID-19 pandemic. All individuals entering the DeGraff Wellness Center are screened as per Kaleida Health policy. This screening included temperature testing and the distribution of a mask. Masks were worn by Mr. Raymond, Ms. Michelle Raymond, and I throughout the examination.

History of the Present Illness:
Mr. Raymond is a 32-year-old male who complains of memory problems, neurogenic bladder, catheterization, painful urination, recurrent urinary tract infections, recurrent pyelonephritis,

personality issues, changes in mood, sleep issues, headache, and lightheadedness due to the 9/14/2016 incident.

Mr. Raymond stated that he was assaulted on 9/14/2016. He stated that he was struck in the head and neck. He said that since the assault he has developed memory problems and therefore has to "write everything down." He said that he feels that his memory problems have increased over the years. He said he is very forgetful.

Mr. Raymond stated that his personality has changed since the incident. He said by nature he is chatty and cheerful, but that he has been more depressed and anxious since the incident.

Mr. Raymond stated that he has sleep problems since the incident. He said he takes sleeping medications with benefit. He said that without the sleeping medications, he would have marked disruption of his sleep cycle.

Mr. Raymond stated that since the time of the incident, he has had headaches on the right parietal area. He said the headaches occur daily. He denied any association of nausea. He said the headaches are associated with flashing lights. He said the headaches last most of the day.

Mr. Raymond stated that since the incident, he has feelings of lightheadedness and wooziness. He denied any spinning sensation. He said he feels unsteady with walking.

Mr. Raymond stated that he has used a suprapubic catheter since the incident. He said that he has constant pain in the abdominal area due to the suprapubic catheter. He said that the catheter itself is painful. He said he also has frequent bladder, urinary, and kidney infections. He said that during a urinary tract infection he experiences fatigue, malaise, nausea and vomiting. He stated that he never used a catheter prior to the incident or had urinary issues of any kind prior to the incident.

Mr. Raymond stated that urinary tract infections lead to increased seizures. He said that he is more likely to have a seizure when he has a urinary tract infection. He said that the urinary tract infection results in nausea and vomiting. He said he vomits his seizure medication and this also leads to increased seizures. He has seizures several times per week.

During the interview, Mr. Raymond had an episode of feeling unwell and had to rest. He felt lightheaded and woozy.

Mr. Raymond stated that his activity level has changed since the incident. He said occasionally drives his motorcycle short distances. He said he has difficulty using the stairs. He said he has difficulty performing most chores. He said he is unable to sustain any reading. He said he spends most of his days sleeping or watching television.

Mr. Raymond stated that he currently undergoes treatment with the neurologist, Dr. Fasanello.

Medical History:

Head injury in 2012 – He was struck in the head with a high beam at work. He said he had loss of consciousness and was taken to the hospital. He said he was hospitalized for two to three weeks. He said he developed seizures. He said his seizures are much worse since the 2016 incident. The seizures also are more likely to occur when he has a urinary tract infection or kidney infection.
No history of urinary issues prior to the 9/14/16 incident.

Social History:
Mr. Raymond stated that he is working as a union bricklayer, master welder, and equipment operator.

Medications:

- Keppra 1500 mg po bid
- Zonisamide 500mg po qhs

Physical Examination:

Blood pressure 110/72, pulse 70, respirations 12. Heart – S1 and S2 were normal. Lungs were clear to auscultation. Carotids were normal bilaterally. No tenderness with palpation at ribs bilaterally. No significant deformity. No swelling.

Mental status: alert and oriented x3. Good naming, repetition and fluency. Decreased attention and concentration. Normal short and long-term memory. Normal mood and affect. Cooperative and polite throughout the examination. Normal language and cognition. Normal fund of knowledge. Understood all questions asked and responded appropriately. No psychomotor retardation or agitation. No thought disturbance.

Cranial nerves: visual fields were full. Extraocular movements were intact. No abnormalities with tracking, saccades or accommodation. Convergence is normal. Pupils were equal, round, and reactive to light. Funduscopic exam was normal. Sensation and movement of face was normal. Trapezius and sternocleidomastoid normal. Normal swallow. Normal hearing.

Motor: Power, tone and bulk normal in the right and left deltoids, biceps, triceps, wrist extensors, wrist flexors, small muscles of hand, gluteal, iliopsoas, hamstrings, quadriceps, foot dorsiflexors, and foot plantar flexors. No fasciculations. There is no evidence of atrophy or disuse. Incoordination finger-nose-finger and heel-knee-shin bilaterally.

Gait wide based.

Extremities showed no evidence of edema or swelling. Extremities exhibited no signs of abnormalities in temperature, skin color, skin characteristics or hair growth. Unable to perform toe and heel walk.

Sensory: Normal pinprick, temperature, vibration, position sense and light touch sensation in the upper and lower extremities.

Negative Tinel's sign, Phalen's signs and reverse Phalen's sign.

Deep tendon reflexes: +2 in the biceps, triceps, brachioradialis, knee and ankle reflexes bilaterally.
Plantar response was downgoing bilaterally.
Positive Hall-pike maneuver.
Range of motion: (performed without assistance, limitations were due only to the subjective complaint of pain)(Source VAMC compensation guidelines; objectively measured by visual observation)
Cervical: (no tenderness, no spasm)

Flexion:	45 (0-45 degrees)
Extension:	45 (0-45 degrees)
Lateral flexion:	45 (0-45 degrees)
Rotation:	80 (0-80 degrees)

Thoracic: (no tenderness, no spasm)
Lumbar: (no tenderness, no spasm)

Flexion:	90 (0-90 degrees)
Extension:	30 (0-30 degrees)
Lateral flexion:	30 (0-30 degrees)
Rotation:	30 (0-30 degrees)

Straight leg raising:
Right: 90 degrees.
Left: 90 degrees.

THE FOLLOWING RECORDS WERE REVIEWED:

I reviewed records relating to Mr. Raymond's medical treatment from the following medical providers in their totality, although not every single treatment date or record is set forth in the list below.

Auburn Community Hospital Emergency Department
8/14/2016 – He was seen for seizure.
9/13/2016 – He was seen for witnessed grand mal seizure. He has a history of seizures. He told neighbor that he did not feel well. He presents from Auburn Correctional Facility after witnessed grand mal seizure. He was found by prison staff lying on cell floor having total body shaking. He was lethargic, but arousable on exam. He needed repeated stimulation. He was given 2 grams of Ativan. The seizure lasted approximately three to five minutes per the staff. He was incontinent of urine. He is noncompliant with taking his medications. He is on Keppra. He presents post ictal and lethargic. He complains of neck pain and headache. He had a grand mal seizure in the emergency room. He was given 2 mg of IV Ativan with resolution. His Keppra is starting now. He has had no further seizure activity. The Keppra was infused. His CTs are negative. He was alert and answering questions.
9/13/2016 – CT of the Cervical Spine – No acute cervical abnormality.
9/13/2016 – CT of the Head – No acute intracranial abnormality. The lesion in the right anterior frontal bone has benign appearance and may represent a dermoid or epidermoid cyst.

9/14/2016 – Emergency Department Progress Note – He was seen for seizure. He has been unable to hold anything p.o. and has abdominal pain and vomiting. He has not been eating much or taking his medication for the past few weeks due to increased abdominal pain and nausea. He has had seizures since 2012 after traumatic brain injury when a steel beam hit him in the head. He was followed by Dr. Singh, a neurologist from Lockport, NY. He was alert and oriented. He did not appear post ictal. He states that he cannot take Dilantin as it gives him hives and burns. No seizure activity was noted in the emergency department during his observation. He became agitated and threatening physically with prison guards, although he remained shackled with hands and feet. He was on Keppra. His Keppra level was pending. It was sent out. The emergency department workup from yesterday was reviewed. He had seizures this morning. He had no loss of consciousness. He also threw up blood and his medications. He was given a dose of Keppra in the emergency department. His Keppra dose at home is 750 mg twice per day. He was administered IV Lorazepam and Levetiracetam 100 mg premix piggyback 1000 mg/100 ml on 9/13/2016 at 15:38. (Not clear if he received a second dose at 16:10.)
9/14/2016 – Levetiracetam level: 13.9, reference range 10-40.

New York State Department of Corrections and Community Supervision
12/22/2015 – He underwent aggression replacement training.
7/2/2016 – He was seen for seizure activity. He was seen for gastrointestinal symptoms.
7/7/2016 – He was brought to the emergency department for seizures.
7/14/2016 – He was seen for seizures. He is not taking his Keppra. He said it upsets his stomach.
9/13/2016 – He had a seizure. He is noncompliant with medications. He complained of neck pain and nausea. He is lethargic and post ictal. He had seizure activity in the emergency department. No obvious trauma. The assessment is grand mal seizure with history of noncompliance with medication. He had an unwitnessed fall with neck pain. He was given Keppra 1 gram IV.
9/13/2016 – 2:00 p.m. – He has continued tonic clonic seizures. He was given Ativan.
9/13/2016 – 7:00 p.m. – He returned from the emergency room with grand mal seizures.
9/14/2016 – 4:25 p.m. - He returned from AMH emergency room after being discharged. He became aggressive and yelling at the emergency room staff. He had seizures while in the emergency room. He disconnected the IV and let the blood drip into his mouth and attempted to recap the IV. Team was sent to the emergency room to escort the inmate back to the facility. Upon return, inmate claims to be having a seizure. He responds appropriately to stimuli. Per security, he was thrashing around in the van and alert and oriented times three. He has red and swollen area to left eye, left cheek, and left ear. He has abrasions to the upper right chest. No other injuries noted or reported during visual assessment. He was admitted to SHU. No medical indication to house in infirmary.
9/14/2016 – 6:10 p.m. – Medical emergency called. Inmate tied sheet around his neck. He is alert and oriented times three. He was sitting up independently. He had a mark on the left side of his face. He was angry that he isn't getting Trileptal and is receiving Keppra.
9/14/2016 – Injury Report – Injury involves the left eye, cheek, and ear noted to have redness and swelling to areas. Abrasions times two noted in upper chest area. Pictorial report reviewed.
9/17/2016 – He complained of abdominal pain.
9/19/2016 – His missed his morning dose of Keppra.

9/28/2016 – He was seen for head. The assessment is head. He is following simple commands. Gross neurologic exam intact. He had no symptoms of seizure.
9/29/2016 – He was seen for seizure related issues.
10/6/2016 – He was seen for burning with urination.
10/12/2016 – He was seen for urinary symptoms.
10/14/2016 – He is status post altercation. He complained of blood in his urine and testicular area, and right groin.
10/19/2016 – He was seen for testicular pain.
10/21/2016 – He was seen for genitourinary symptoms.
1/9/2017 – He was seen for dysuria.
1/19/2017 – He was seen for genitourinary symptoms.
1/29/2017 – He was seen for abdominal pain.
2/9/2017 – He was seen for back pain.
2/10/2017 – He was seen for his catheter.
2/22/2017 - He was seen for catheter.
3/2/2017 – He was seen for genitourinary symptoms.
3/13/2017 – He was seen for gastrointestinal symptoms.
4/12/2017 - He was seen for issues regarding his catheter.
4/26/2017 – He was seen for abdominal pain.
4/28/2017 - He was seen for genitourinary symptoms.
5/8/2017 - He was seen for genitourinary symptoms.
5/20/2017 – He complained that Keppra was making him sick to his stomach.
5/23/2017 – He was seen for catheter issues.
5/24/2017 – He was seen for genitourinary symptoms.
5/25/2017 - He was seen for genitourinary symptoms.
5/27/2017 – He was seen for back pain.
6/25/2017 – He was seen for blood in his urine.
6/26/2017 – He was seen for urinary symptoms.
7/20/2017 – He complained that his Keppra was making him sick to his stomach.
7/30/2017 – He was seen for urinary symptoms.
8/2/2017 - He was seen for catheter.
8/17/2017 – He was seen for catheter.
8/20/2017 - He was seen for catheter.
8/24/2017 – He was seen for catheter.
8/31/2017 – He was seen for catheter.
9/13/2017 – He was seen for issues regarding his catheter.
10/12/2017 – He was seen for his catheter.
10/26/2017 – He was seen for body aches.
11/3/2017 – He was seen for gastritis, seizures, and catheter.
11/27/2017 – He was seen for suprapubic catheter.
12/14/2017 – He was seen for recurrent pyelonephritis.
12/15/2017 – He was seen for his catheter.
12/22/2017 – He was seen for burning and CVA tenderness.
12/29/2017 – He was seen for nausea and vomiting.
1/14/2018 – He was seen for suprapubic catheter.
11/7/2018 – Ambulatory Health Record – His suprapubic catheter was changed.

Upstate University Hospital
1/19/2017 – He was seen for urinary issues.
2/10/2017 – He was seen for urinary issues.
3/30/2017 – He was seen for urinary issues.
4/26/2017 – He was seen for urinary tract infection.
6/9/2017 - Admission: 6/6/2017. Discharge: 6/9/2017. He was seen for urinary tract infection.
7/30/2017 – He was seen for genitourinary symptoms.
9/10/2017 – Admission: 9/5/2017. Discharge: 9/10/2017. He was seen for genitourinary symptoms.
3/13/2018 – He was seen for urinary issues.
5/29/2018 – He was seen for urologic issues.
7/7/2018 – Admission: 7/5/2018. Discharge: 7/4/2018. He was seen for gastrointestinal illness.

Elmira CF Mental Health
9/14/2016 – 6:20 p.m. - He was admitted to SHU for combative behavior, questionable feigned seizure. He was angry, tense, and marginally cooperative.
9/14/2016 – 6:30 p.m. – He was uncooperative, restless, agitated, threatening, and aggressive.

Central New York Psychiatric Center
12/10/2015 – He described his mood as "pretty good".
12/11/2015 – He was seen for depression.
12/22/2015 – He was seen for depression and anxiety.
1/12/2016 – He was seen for depression.
1/19/2016 – He was seen for depression. It was noted that he had an allergy to Dilantin.
2/9/2016 – He underwent therapy for depression.
2/16/2016 – He was seen for depression.
3/9/2016 – He underwent therapy for depression.
4/8/2016 - He underwent therapy for depression.
4/19/2016 – He was seen for depression.
5/6/2016 – He underwent therapy for depression.
6/6/2016 - He underwent therapy for depression.
6/14/2016 – He was seen for depression.
7/27/2016 - He underwent therapy for depression.
8/17/2016 – He was seen for depression.
8/30/2016 - He underwent therapy for depression.
9/14/2016 - He was found with a noose in his cell. "I came to from having a seizure and is getting my ass whooped and lieutenant grabbing me inappropriately". He later described the incident as happening when he was brought to SHU and after returning from the hospital. When asked about this discrepancy, he stated that there were two separate incidents. He was informed of his right to report this to acting unit chief. He reported that he had no idea why he was brought to SHU. He denied having a noose in his cell. He denied thoughts of self-harm and/or suicide. He reports he has not been regularly taking his seizure medications which is likely what brought on the seizure. He reported he has safety concerns about returning to SHU after this incident.
9/15/2016 – He stated that he was assaulted the day prior.

9/19/2016 – He reports he is good. He has had no self-harming behaviors.
10/27/2016 – He was seen for depression and seizure disorder.
12/13/2016 - He underwent group therapy for depression.
2/9/2017 - He underwent group therapy for depression.
3/13/2017 - He underwent group therapy for depression.
5/1/2017 – He was seen for depression.
5/3/2017 - He underwent group therapy for depression.
5/13/2017 – He was seen for depression.
6/20/2017 – He was seen for depression.
6/26/2017 - He underwent group therapy for depression.
7/25/2017 - He underwent group therapy for depression.
8/25/2017 - He underwent group therapy for depression.
9/26/2017 - He underwent group therapy for depression.
10/18/2017 - He underwent group therapy for depression.
11/29/2017 – He was seen for depression.
1/11/2018 – He was seen for depression.

Arnot Ogden Medical Center
3/10/2018 – He was seen for genitourinary symptoms.
3/22/2018 - Admission: 3/20/2018. Discharge: 3/22/2018. He was seen for genitourinary symptoms.
5/3/2018 – He presents for seizure after altercation with head injury today. He remembers being hit in the head and the next thing he remembers is waking up in the emergency department. He was found in his cell with seizure activity. He was unresponsive. He was brought to medical and given Ativan. He was post ictal on arrival. He reports nausea, vomiting, and unable to tolerate his medications. He is maintained on Zonegran for seizures. He was seen the day prior for seizure during altercation that resulted in head and neck contusions. On exam, he appeared in mild pain and distress. He has contusions to the left frontal and scattered abrasion to the left face and right anterior neck. He had scattered healing abrasions and hematoma on the left forehead. Diagnosis is urinary tract infection and seizure.
5/10/2018 – Admission: 5/3/2018. Discharge: 5/10/2018. He was seen for genitourinary symptoms.
5/27/2018 – He was seen for seizures.

Mobile Physician Services
8/1/2018 – He was seen for genitourinary symptoms.
8/8/2018 – He was seen for plugged catheter.
8/26/2018 – He was seen for genitourinary issues.
9/1/2018 – He was seen for genitourinary issues.
9/3/2018 – He was seen for genitourinary issues.
9/30/2018 – He was seen for seizure.
10/8/2018 – He was seen for hematuria.
10/14/2018 – He was seen after passing out due to flank pain.
10/17/2018 – He was seen for flank pain.

Erie County Medical Center
7/27/2018 – He was seen for genitourinary issues.
8/2/2018 – He was seen for genitourinary issues.
8/6/2018 – He was seen for genitourinary issues.
8/15/2018 – Admission: 8/14/2018. Discharge: 8/15/2018. He was seen for genitourinary issues.
8/26/2018 – He was seen for genitourinary problems.
9/2/2018 – He was seen for abdominal pain.
10/9/2018 – He was seen for genitourinary issues.
10/14/2018 – He was seen for flank pain.
10/26/2018 – He had a witnessed thirty minute seizure which resolved with 2 mg of Ativan.
10/28/2018 – He was discharged for genitourinary issues.
11/20/2018 – He was seen for genitourinary issues.
1/2/2019 – He was admitted for frequent seizures with history of epilepsy and traumatic brain injury.
1/4/2019 – EEG – No abnormality.
1/6/2019 – Discharge Summary – Admission: 1/2/2019. Discharge: 1/6/2019. He was seen for break through seizures and genitourinary issues.

Wyoming County Community Hospital
9/30/2018 – He was seen for seizure and urinary tract infection.
10/22/2018 – Admission: 10/20/2018. Discharge: 10/22/2018. The admitting diagnosis was abdominal pain and seizure.
1/25/2019 – He was seen for seizures.
7/4/2019 – He was seen for seizure disorder and urinary tract infection. He was seen for side pain and vomiting.

Kenmore Mercy Hospital
1/22/2014 – He was seen for abnormal episodes.
1/25/2014 – He was seen for seizures. **EEG showed bifrontal relatively frequent sharp activity**.
1/28/2014 – He was seen for seizure.
6/10/2014 – He was seen for seizures.
3/25/2015 - Admission: 3/23/2015. Discharge: 3/25/2015. He was seen for break through seizure.

Westfield Memorial Hospital Emergency Department
5/31/2015 – He was seen for seizures.

Cayuga Medical Center
12/31/2015 - Admission: 12/30/2015. Discharge: 12/31/2015. He was seen for appendicitis.

Erie County Medical Center
2/12/2019 - He was seen for seizure, pyelonephritis, hypokalemia, right flank pain, urinary tract infection, and neurogenic bladder.

6/3/2019 – Admission: 6/3/2019. Discharge: 6/4/2019. He was seen for break through seizures and urinary tract infection.
6/4/2019 – He was seen for seizures.
7/1/2019 – Admission: 7/1/2019. Discharge: 7/2/2019. He was seen for break through seizure. He was seen for bladder issues.
9/22/2019 – He was seen for urinary tract infection. He was seen for seizures.
9/23/2019 – He was seen for tube change.
9/24/2019 – Admission: 9/24/2019. Discharge: 9/25/2019. He was seen for break through seizures.
10/15/2019 – Admission: 10/15/2019. Discharge: 10/17/2019. He was seen for recurrent seizure.
10/27/2019 – Admission: 10/27/2019. Discharge: 10/28/2019. He was seen for recurrent seizures and urinary tract infection.
10/30/2019 – Admission: 10/30/2019. Discharge: 11/6/2019. He was seen for break through seizures, neurogenic bladder, recurrent urinary tract infections, and dehydration.
11/18/2019 - Admission: 11/18/2019. Discharge: 11/20/2019. He was seen for break through seizures. He was seen for allergic reaction.
12/3/2019 – He was seen for break through seizure.
12/8/2019 – Admission: 12/8/2019. Discharge: 12/9/2019. He was seen for recurrent seizure.
2/10/2020 – Discharge Summary – Admitting diagnosis: Nausea. Discharge diagnosis: Nausea resolved and seizure activity. He had a seizure.
2/27/2020 – He was seen in the emergency department. He was just released from Attica prison. Not all of his medications were refilled. The primary impression was medication refill.
7/6/2020 – He was seen for psychiatric issues.

Wyoming County Medical Center
7/27/2019 – He was seen for seizure.

Trinity Medical WNY
3/9/2020 – He was seen for blood in stool and pain following kidney infections. He has suprapubic catheter and recurrent urinary tract infections.
6/6/2020 – He was seen for neuropathy.
7/23/20 -He was seen for annual physical exam.
11/10/20 – He was seen for pre-procedure exam.
1/4/2021 – He was seen multiple issues.

WNY Urology Associates
3/10/2020 - He was seen for flank pain and neurogenic bladder.
4/20/2020 – He was seen for flank pain and neurogenic bladder.
5/22/2020 – He was seen for flank pain and neurogenic bladder.
6/23/2020 – He was seen for 3 week catheter change.
7/15/2020 – He was seen for 3 week catheter change.
9/21/2020 – He was seen for 3 week catheter change. He has neurogenic bladder.
11/27/2020 – Call was about exudate from incision.
12/9/2020 – He was seen for wound check s/p bladder augmentation surgery. He has post operative wound infection and dehiscence.

John Bodkin III, MD
8/31/2020 – He as seen for neurogenic bladder with blood clots in urine.

Kaleida Health
11/17/20 - He underwent augmentation cystoplasy with Indiana pouch continent urinary diversion for neurogenic bladder.
11/30/2020 – He underwent US guided aspiration of abdominal abscess.

State of New York Department of Corrections & Community Supervision (Handwritten Notes)
1/25/2019 – He was seen for seizures.
2/13/2019 – He was seen for break through seizures
2/24/2019 – He was seen for urinary symptoms.
3/20/2019 – He was seen for seizures.
5/20/2019 – He was seen for seizure.
5/25/2019 – He was seen for follow-up of seizures.
5/31/2019 – He was seen for urinary tract infection and seizures.
6/11/2019 – He was seen for seizures.
7/28/2019 – He was seen for seizures.
8/21/2019 – He was seen for seizures.
9/21/2019 – He was seen for generalized seizure activity.
10/13/2019 – He was seen for seizures.
10/26/2019 – He was seen for seizure.
10/28/2019 – He complained of seizures.
11/21/2019 – He was seen for seizures.
12/3/2019 – He was seen for seizure.
12/7/2019 – He was seen for seizures.
12/26/2019 – He was seen for seizures.
1/25/2020 – He was seen for seizure.
2/9/2020 - Ambulatory Health Progress Record – He was seen for seizures.

Elmira Pharmacy: Reviewed.

State of New York Correctional Services 3/8/2016. Statement discusses drug use.

State of New York Correctional Services 4/22/2016. The report describes an issue with his ID.

DIAGNOSTIC TESTING:

Auburn Hospital Emergency Department
9/13/2016 – CT of the Cervical Spine – No acute cervical abnormality.
9/13/2016 – CT of the Head – No acute intracranial abnormality. The lesion in the right anterior frontal bone has benign appearance and may represent a dermoid or epidermoid cyst.

Upstate University Hospital
6/28/2017 – CT of the Abdomen & Pelvis – Enhancing lesion in the left kidney.

Erie County Medical Center
7/21/2016 – EEG – Normal.
1/4/2019 – EEG – No abnormality.

Wyoming County Community Health Systems
1/25/2019 – CT of the Head – No abnormality.

WCA Hospital
11/23/2015 – CT of the Head – Normal.

Erie County Medical Center
2/9/2020 – CT of the Abdomen – No evidence of acute abdominal process.
2/10/2020 – CT of the Cervical Spine – No acute fractures.

Amended Complaint: On 9/14/2016 while in the custody of the New York State Department of Corrections and Community Supervision, Mr. Raymond was water boarded and violently assaulted with blows to the head, neck, chest, and groin. It was noted that before his incarceration in 2015, while working on a construction site, he suffered traumatic brain injury that resulted in occasional seizures. On September 13, 2016, he suffered a seizure at Auburn and was transported to Auburn Community Hospital for evaluation. On September 14, 2016, he suffered a seizure during his transported, he was shackled at the ankles and handcuffed at the wrists and his hands were connected by a chain and placed in a black box. Throughout the September 14, 2016 incident, his hands were in the black box and his ankles were in shackled. On September 14, 2016, while disoriented and confused, after his most recent seizure, he sat up suddenly from his hospital bed. He developed another seizure while transporting back to Auburn and vomited in the vehicle. Upon return to Auburn, he was taken to a small room known as an emergency treatment room. He was violently assaulted. He was water boarded holding his head down by his hair, pulling his shirt up over his face and slowly dripping a large bucket of water in his nose and mouth. He was punched on and around his face, neck, and chest.

Department of Correctional Services Inmate Photographs: Reviewed.

Auburn Correctional Facility Hearing 9/23/2016: Reviewed.

Conclusion:

Mr. Raymond is a 32-year-old male who was assaulted while incarcerated on 9/14/16. According to Mr. Raymond, during the assault he was struck on the face, head, and neck with fists and a baton. He complains of memory problems, neurogenic bladder, catheterization, painful urination, recurrent urinary tract infections, personality issues, changes in mood, sleep issues, headache, and lightheadedness.

Mr. Raymond's description of the 9/14/16 incident and the medical records demonstrate that he suffered a traumatic brain injury on 9/14/16. At the time of the incident Mr. Raymond was neurologically compromised due to previous head injury and seizure disorder. It is well-established in the literature that recurrent head injury in an already neurologically compromised individual can result in more significant and serious deficits. In Mr. Raymond's case, the pre-existing head injury and seizure disorder rendered him at increased risk of severe sequelae from traumatic brain injury. The 9/14/16 incident resulted in severe traumatic brain injury with new findings of persistent post-traumatic neurologic injury including neurogenic bladder, headache, personality change, sleep problems, lightheadedness and increased risk of seizures.

Mr. Raymond developed urinary symptoms soon after the incident. The urinary symptoms are due to neurogenic bladder dysfunction. Neurogenic bladder dysfunction refers to urinary bladder problems due to injury of the central nervous system. Ordinarily, nerves transmit messages between the bladder, spinal cord, and brain and tell the bladder muscles when to tighten or release. In individuals with neurogenic bladder, however, these nerves do not function properly and thus do not transmit sufficient messages to the bladder muscles. Traumatic brain injury is a well-established cause of neurogenic bladder. The temporal course of Mr. Raymond's symptoms and signs of neurogenic bladder indicates that the events of 9/14/16 resulted in neurogenic bladder.

Auburn Correctional Facility records reflect that Mr. Raymond was not referred to a urologist for further screening and treatment until January 19, 2017—four months after the incident. During that four-month period, records reflect that Mr. Raymond made six sick calls to the infirmary, presenting variously with abdominal pain, pain with urination, recurring hematuria and gross hematuria, scrotal/testicular pain, severe groin pain, distended bladder, urinary retention, and suprapubic discomfort. These severe symptoms, particularly when they recur over a period of months, can indicate any number of severe medical conditions (including neurogenic bladder, chronic kidney disease, kidney failure, sepsis, urethral stricture, and infertility). Any of these conditions requires a full medical assessment (which records reflect did not occur) and, ultimately, treatment beyond antibiotics for urinary tract infections and pain relief, the primary steps Auburn staff took in response to Mr. Raymond's ongoing symptoms. Prompt treatment would likely have resulted in a better prognosis for Mr. Raymond's neurogenic bladder and other urinary symptoms. Properly-trained medical staff should have recognized that Mr. Raymond's symptoms required a prompt urology referral. This is particularly true given that at least some treatment records reflect that Mr. Raymond was experiencing pain following "recent trauma."

Neurogenic bladder is associated with frequent urinary tract infections. Mr. Raymond has frequent urinary tract infections with urinary symptoms and symptoms of fatigue, malaise, nausea and vomiting.

The neurogenic bladder was treated with a suprapubic catheter and bladder augmentation surgery. Catheter placement and the bladder surgery occurred after the 9/14/16 incident. The 9/14/16 incident resulted in suprapubic catheter placement and bladder augmentation surgery (known as "bladder augmentation cystoplasty"). Bladder augmentation surgery enlarges the bladder's capacity to treat a variety of urinary conditions, including neurogenic bladder. Medical records reflect that Mr. Raymond's augmentation procedure was postoperatively complicated by wound infection, wound dehiscence, fever, and persistent pain beneath his stoma. Mr. Raymond will have to manage his neurogenic bladder condition for the rest of his life. He will be required to receive ongoing treatment, evaluation, and likely additional surgical procedures. There is no cure for neurogenic bladder, and Mr. Raymond's records reflect that his condition will likely be progressive due to accelerated aging stemming from his traumatic brain injuries.

Mr. Raymond states that since the incident he has experienced headache, personality change, sleep problems and lightheadedness. Review of the records from prior to 9/14/16 accident shows no significant history of headache, personality change, sleep problems and lightheadedness. It is well established in the literature that headache, personality change, and sleep problems and lightheadedness are sequelae of traumatic brain injury. Mr. Raymond's current complaints are related to the 9/14/16 incident.

In my professional opinion and to a reasonable degree of medical certainty, the records and documents I have reviewed present no other cause of Mr. Raymond's neurogenic bladder. Neurogenic bladder does not arise spontaneously, with no cause at all. In addition, Mr. Raymond's 2012 traumatic brain injury would not have caused his neurogenic bladder condition to arise in late 2016, particularly since records reveal that the bladder condition arose just weeks after the 9/14/16 assault. Finally, Mr. Raymond's neurogenic bladder did not arise from improper catheter care, his seizure disorder, or any drug use or drug addiction.

Mr. Raymond states that his seizure disorder is more severe since the 9/14/16 incident. Trauma to the brain is known to cause worsening of certain underlying conditions including seizure disorder. In addition, recurrent infections, including urinary tract infections, result in lowering of the seizure threshold and increased seizures. The nausea and vomiting that is associated with the urinary tract infections results in decreased absorption of seizure medications leading to increased seizures. Also, the 9/14/16 incident is associated with poor sleep. Poor sleep is associated with lowering of the seizure threshold and increased seizures. Thus, the 9/14/16 incident resulted in increased seizures due to traumatic brain injury, frequent infection, gastrointestinal symptoms and poor sleep.

Review of medical records from 9/13/16 and 9/14/16 indicates that Mr. Raymond experienced recurrent grand mal seizures on both days. The seizures were followed by a post ictal period of aggression, agitation and confusion. He was treated with IV Ativan and Keppra. Post-ictal periods involving change in mental status typically occur after grand mal seizures. The post-ictal periods frequently involving confusion and combative behavior. In addition, Keppra has a known side effect of aggression. Confusion can occur with Ativan and exacerbate aggression. Medical management of seizures and the subsequent post ictal period is focused on seizure cessation, cardiovascular stability and prevention of injury. Medical management does not involve shackling, assaulting or retaliatory actions toward individuals with seizures.

In my professional opinion, and to a reasonable degree of medical certainty, I have concluded that:

1) **9/14/16 assault on Mr. Raymond resulted in a second, separate traumatic brain injury**, and
2) **Mr. Raymond's current diagnosis of neurogenic bladder was caused by the physical assault he sustained on 9/14/16**.

DR. SHERRY WITHIAM-LEITCH

DATE: 7/22/21

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EDUCATION

MD: 1992, SUNY at Buffalo School of Medicine, Magna Cum Laude
BS: 1988, SUNY at Buffalo, Summa Cum Laude

EMPLOYMENT HISTORY

Chief of Neurology VAMC Buffalo, 2010-present
Director Veterans Neurologic Injury, 2012-present
Assistant Professor of Neurology, SUNY at Buffalo, July 1996-present
Faculty Appointment, D'Youville College, Buffalo, September 1998-2001
Residency: Neurology, SUNY at Buffalo, 1992-1996
Internship: SUNY at Buffalo, 1992-1993

LICENSURE AND BOARD CERTIFICATION

1997 American Board pf Psychiatry and Neurology
1996 New York State Education Department, Division of Professional Licensing
1993 National Board of Medical Examiners

HOSPITAL APPOINTMENTS

Kaleida Health System, Buffalo, NY
Veteran's Administration Medical Center, Buffalo, NY
Mt. St. Mary's Hospital, Lewiston, NY

AWARDS:

Kaleida Health Recognition Awards Program, 2006
American Medical Association Physician's Recognition Award, 2004-2006

RESIDENCY HONORS

Outstanding Research Award, Department of Neurology, 1996
House Staff Award for Excellence in Teaching, 1992-1993

MEDICAL SCHOOL HONORS

Janet M. Glasgow Citation for Academic Excellence, 1992
American Federation of Aging Research National Scholarship, Duke University School of Medicine, 1990
Traveler's Geriatric National Fellowship, National Council on the Aging, 1989
Dean's Commendation for Academic Excellence, SUNY at Buffalo, 1989
Gibson Anatomical Honor Society, SUNY at Buffalo, 1989

Award for Outstanding Student in Physiology, SUNY at Buffalo, 1989
Dean Scholarship, 1988-1992

TEACHING EXPERIENCE

Clinical Instruction, SUNY at Buffalo, residents and medical students, 1996-present
Neurology Clinical Cases, SUNY at Buffalo, second year medical students, 1999
Astrocyte Cell Biology, SUNY at Buffalo, graduate school, 1998
Physician's Assistant Program, D'Youville College, 1994-1999
Gross Anatomy, Daemen College, 1989
Remedial Medical Biochemistry, SUNY at Buffalo, 1989
Comparative Primate Anatomy, SUNY at Buffalo, 1988